BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

SHAWN A. NEY	)	
Claimant	)	
	)	
VS.	)	
	)	
GENERAL FINANCE, INC.	)	
Respondent	)	Docket No. 1,037,855
	)	
AND	)	
	)	
PHOENIX INSURANCE COMPANY	)	
Insurance Carrier	)	

ORDER

STATEMENT OF THE CASE

Claimant requested review of the May 7, 2010, Award entered by Administrative Law Judge John D. Clark. The Board heard oral argument on August 20, 2010. Roger A. Riedmiller, of Wichita, Kansas, appeared for claimant. Ali N. Marchant, of Wichita, Kansas appeared for respondent and its insurance carrier (respondent).

The Administrative Law Judge (ALJ) found that claimant had a 12 percent permanent partial impairment to the left upper extremity at the level of the shoulder. The ALJ further found that claimant had a preinjury average weekly wage (AWW) of $849.45.

The Board has considered the record and adopted the stipulations listed in the Award. Also, during oral argument to the Board, the parties stipulated that claimant's gross average weekly wage is $849.85.

ISSUES

Claimant requests review of the ALJ's finding that he was limited to a scheduled injury. Claimant argues that the evidence shows he is entitled to a work disability as a result of having sustained an injury to the body as a whole. Claimant also argues that the ALJ incorrectly calculated claimant's preinjury AWW.[1] Although claimant's Request for

[1] The parties are both contending that claimant's preinjury AWW was $849.85. The ALJ found claimant's AWW to be $849.45. Either amount would entitle claimant to the maximum weekly compensation rate of $483.

Review lists as an issue whether claimant is entitled to unauthorized medical or future medical, that issue was not addressed in claimant's brief to the Board or in claimant's submission letter to the ALJ. During oral argument to the Board, claimant explained that medical treatment was an issue only in respect to the question of the nature and extent of claimant's disability.

Respondent contends that the ALJ correctly determined that claimant is entitled to an award based on a scheduled injury to the left shoulder only.

The issue for the Board's review is: What is the nature and extent of claimant's disability?

FINDINGS OF FACT

Claimant started working for respondent in December 1999 as a brick hacker. Later, he moved into the position of a grinding room operator, where he operated the daily schedule of grinding clay for the plant. Both claimant and respondent agree that his preinjury AWW is $849.85.[2] On May 17, 2007, some clay had gotten stuck to the sides of a bin. Claimant used a long air wand and air hose attached to a rope to break the clay from the sides of the bin. He had wrapped the hose around his left arm for leverage. But the clay on the sides broke away and pulled the air wand. Claimant almost fell into the bin, but his foot caught the rail behind him. Claimant was taken to Clara Barton Hospital, where he complained of pain in his neck, left shoulder and back. He was x-rayed and given a sling. He was told to keep his arm stationary and was given pain medication.

Respondent sent claimant to Dr. Eric Severud for medical treatment. After physical therapy and some muscle stimulation, Dr. Severud performed arthroscopic surgery on claimant's left shoulder on August 31, 2007. Claimant was again sent to physical therapy. When his left shoulder continued to be painful, Dr. Severud recommended a second surgery. Respondent then sent claimant to Dr. John McAtee for a second opinion. After examining claimant, Dr. McAtee diagnosed him with snapping scapula syndrome, a painful condition where there is popping in the back of the shoulder due to a small spur or prominence of the superior medial scapula. Dr. McAtee recommended a cortisone injection.

After performing the independent medical examination of claimant, Dr. McAtee was authorized to be claimant's treating physician. Dr. McAtee saw claimant on March 3, 2008, at which time he gave claimant a cortisone injection in his subscapular area. Claimant said the injection gave him only a couple days of relief from his pain. Dr. McAtee then recommended a second surgery to resect the top corner of the scapula. That surgery was

[2] This figure is inclusive of items of additional compensation, including the weekly value of the employer's contribution towards claimant's retirement account in the amount of $79.99, which ended on the date of accident.

performed on May 23, 2008, and left claimant with an approximately 6-inch scar. Claimant had physical therapy and continued to see Dr. McAtee post-surgery. Claimant returned to Dr. McAtee on September 15 complaining of constant pain in his neck and intermittent pain in his posterior shoulder, and Dr. McAtee injected claimant's trigger points. Claimant returned on October 27. At that time, Dr. McAtee determined claimant was at maximum medical improvement.

Dr. McAtee's last visit with claimant was on January 7, 2009. He had been authorized to examine claimant's right thumb, which claimant had injured in physical therapy. Dr. McAtee thought claimant primarily had a sprain of his metacarpal joint and his metacarpal phalangeal joint. By the time he saw claimant in January 2009, claimant had improved significantly, and Dr. McAtee did not think there was any treatment to offer.

Dr. McAtee said that he did not believe claimant had radicular pain. It was Dr. McAtee's impression that most of claimant's pain was from the scapula thoracic joint and the scapula thoracic bursitis and crepitation or snapping that occurred at that level. Further, he believed most of the tingling sensation claimant was feeling was related to the soft tissues rather than radiculopathy.

Based on the AMA *Guides*,[3] Dr. McAtee rated claimant as having a 10 percent impairment of his left upper extremity. He did not assign any impairment for claimant's right thumb, neck or cervical spine. When he gave claimant the 10 percent rating, he took into account his pain. Dr. McAtee placed work restrictions on claimant of no lifting greater than 40 pounds, no pushing or pulling greater than 30 pounds, and occasional overhead activity.

Dr. George Fluter is board certified in physical medicine and rehabilitation. He examined claimant on February 18, 2009, at the request of claimant's attorney. Claimant gave Dr. Fluter a history of his accident and his medical treatment, and Dr. Fluter reviewed his medical records.

In discussing claimant's second surgery, Dr. Fluter indicated that a piece of bone was removed from a portion of claimant's scapula that was close to the spine. In performing the surgery, Dr. McAtee had to split a portion of the trapezius muscle in order to get access to the scapula. He also had to separate certain muscle groups, particularly the rhomboid and levator scapulae muscle from the shoulder blade in order to cut out the superior medial border of the scapula. Then he had to reattach those muscles to the remaining portion of the shoulder blade and to re-approximate the split fibers in the trapezius muscle. The trapezius muscle that Dr. McAtee had to operate through has attachments to the base of the skull, to the shoulder girdle, and to the cervical and thoracic portions of the spine. The trapezius and rhomboid muscles are attached to the cervical

[3] American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed.). All references are based upon the fourth edition of the *Guides* unless otherwise noted.

and thoracic portions of the spine. If those have been injured or painful, Dr. Fluter said claimant may have neck and upper back pain.

When Dr. Fluter saw claimant on February 18, 2009, claimant indicated he had pain affecting the left side of the neck and left upper shoulder area, left shoulder girdle, and right wrist. He rated his pain level as a 6 on a 0 to 10 scale. He described the pain as aching, burning, and shooting. He indicated he had some numbness in his neck that would go down into the back, and he had some weakness of the left shoulder girdle.

After the physical examination, Dr. Fluter diagnosed claimant with left shoulder pain and impingement, left shoulder internal derangement for which he underwent left shoulder arthroscopy in August 2007, left-sided snapping scapula for which he underwent surgery in May 2008, neck and upper shoulder pain, cervicothoracic sprain/strain, myofascial pain affecting the neck and left upper shoulder, and right wrist pain related to a sprain that occurred during physical therapy. He believes there is a causal relationship between claimant's condition and the injury at work in May 2007. Dr. Fluter believed claimant had a soft tissue myofascial component of neck and upper back pain partially caused by the accident when his left arm and shoulder girdle were pulled down. Because of the type of surgery claimant had, his myofascial pain was probably a combination of the trauma and the cutting of the muscle in the surgery.

Using the AMA *Guides*, Dr. Fluter opined that claimant had a DRE Category II cervicothoracic spine impairment for a 5 percent permanent partial impairment to the body as a whole. Also, he rated claimant with a 4 percent impairment to his right upper extremity for range of motion deficits. He rated claimant with a 10 percent impairment to the left upper extremity at the level of the shoulder for range of motion deficits. He rated claimant with a 10 percent impairment to the left upper extremity for claimant's distal clavicle resection arthroplasty at the left shoulder. He assigned an additional 5 percent impairment to the left upper extremity for the partial resection of the scapula related to the snapping scapula syndrome. The impairments to the left upper extremity combine for a 23 percent at the level of the shoulder, which would convert to 14 percent to the body as a whole. The 4 percent impairment to the right upper extremity at the level of the wrist would convert to a 2 percent impairment to the body as a whole. The body as a whole ratings combine for a total whole body impairment of 20 percent.

Dr. Fluter recommended that claimant should restrict lifting, carrying, pushing and pulling to 35 pounds occasionally and 15 pounds frequently. He should avoid holding his head and neck in awkward or extreme positions. Overhead activities should be restricted to an occasional basis. Activities at or above shoulder level using the left arm should be restricted to an occasional basis. Activities greater than 24 inches away from the body using the left arm should be restricted to an occasional basis. Repetitive grasping using the right hand should be limited to an occasional basis, and repetitive flexion and extension of the right wrist should be restricted to an occasional basis. Dr. Fluter reviewed a task list

prepared by Jerry Hardin. Of the 48 nonduplicated tasks on the list, he opined that claimant was unable to perform 17 for a 35.4 percent task loss.

Claimant had prior surgery on his right hand in 2004. Dr. Fluter noted that claimant had a nodule near the flexor crease of the right wrist that appeared cystic in nature. It felt to him like it could be some type of synovial cyst or ganglion cyst. That would not be related to his work injury. Dr. Fluter based his determination that claimant's current right hand pain was related to the incident during his physical therapy on the history that claimant had the pain following the pushups. He assigned the 4 percent impairment based on range of motion deficits as a result of that right wrist injury. He had not measured claimant's range of motion before the work-related injury. Dr. Fluter admitted that claimant may have had reduced range of motion from his 2004 injury and surgery.

Dr. David Hufford, who is board certified in family practice with an emphasis in orthopedic sports medicine and who is also a certified independent medical examiner, examined claimant on April 30, 2009, at the request of the ALJ. Dr. Hufford found no vertebral tenderness in the cervical spine or cervical paraspinal muscles, but did find tenderness in the scapular elevators. Dr. Hufford diagnosed claimant with traction injury to the left upper extremity resulting in a right shoulder arthroscopy and medial scapular excision.

Dr. Hufford believes claimant is having chronic neck pain as a result of his injury. Dr. Hufford said more likely than not, the pain claimant experiences in the cervical spine is a result of the direct injury to the left shoulder rather than an injury to the cervical spine.

Claimant testified that Dr. Hufford's examination was very short and that claimant did not push on his neck to check for tenderness or do any range of motion testing. Harold Wiley, an uncle to claimant's wife, went with claimant to the examination. He also testified that the examination was very short. He said Dr. Hufford put his arm on claimant's shoulder and had claimant bring his arm up as far as he could, and that was the only time Dr. Hufford touched claimant. He said Dr. Hufford did not go to claimant's back to examine the surgical scar. In his deposition, Dr. Hufford explained his examination process. He denied claimant's allegation that he did not examine claimant's neck. He testified he examined claimant's shoulder and neck for range of motion. Dr. Hufford testified he believes he examined claimant sufficiently and spent enough time with him that he felt comfortable assessing permanent impairment to him.

Dr. Hufford rated claimant as having a 2 percent impairment to the left upper extremity for his range of motion deficit and a 10 percent impairment to the left upper extremity for the acromioplasty and distal clavicle excision. These impairments combine for a total 12 percent permanent partial impairment to the left upper extremity at the level of the shoulder. Dr. Hufford assigned no impairment to claimant for his cervical spine or his right thumb.

Dr. Hufford testified that claimant had referred pain from the left shoulder into the left side of the neck. He said that if he used Chapter 15 of the AMA *Guides*, the pain chapter, he would have given claimant no more than a 5 percent impairment to the body as a whole for pain. He would then reduce claimant's 12 percent impairment rating to the left upper extremity to 2 percent, which would convert to a 1 percent impairment to the whole body. These would combine to a 6 percent impairment to the body as a whole. However, Dr. Hufford testified that Chapter 15 is very nonspecific and any physician using it is left to his or her subjective opinion of a person's level of pain. He said the usual guidance from most experts is that Chapter 15 should only be used as a fall back method of assigning impairment when no other method is appropriate. Dr. Hufford said that he considered claimant's cervical spine when rating claimant's impairment but was unable to identify pathology in the cervical spine. Therefore, he assigned the rating as an impairment directly to the left upper extremity. He believes that 12 percent to the left upper extremity is an appropriate rating for claimant.

Dr. Hufford gave claimant permanent restrictions of no lifting greater than 35 pounds at any time, occasional lifting limited to 15 pounds, and frequent lifting limited to 7 pounds. Dr. Hufford recommended that claimant limit overhead use of the left arm above horizontal.

Claimant's last day of working for respondent was on the day he was injured. He received a letter in November 2007 terminating his employment with respondent. He received temporary total disability benefits through the last week of October 2008. A few days after receiving his last temporary total disability check, he found work as a certified nurses' aide (CNA) and certified medical aide (CMA).

PRINCIPLES OF LAW

K.S.A. 2009 Supp. 44-501(a) states in part: "In proceedings under the workers compensation act, the burden of proof shall be on the claimant to establish the claimant's right to an award of compensation and to prove the various conditions on which the claimant's right depends."

K.S.A. 2009 Supp. 44-508(g) defines burden of proof as follows: "'Burden of proof' means the burden of a party to persuade the trier of facts by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true on the basis of the whole record."

"A claimant's testimony alone is sufficient evidence of his own physical condition."[4] "Medical evidence is not essential or necessary to establish the existence, nature, and

[4] *Hanson v. Logan U.S.D. 326*, 28 Kan. App. 2d 92, 95, 11 P.3d 1184, *rev. denied* 270 Kan. 898 (2001).

extent of a worker's injury."[5] A factfinder must decide what medical opinion is most credible.[6]

K.S.A. 44-510e(a) states in part:

> If the employer and the employee are unable to agree upon the amount of compensation to be paid in the case of injury not covered by the schedule in K.S.A. 44-510d and amendments thereto, the amount of compensation shall be settled according to the provisions of the workers compensation act as in other cases of disagreement, except that in case of temporary or permanent partial general disability not covered by such schedule, the employee shall receive weekly compensation as determined in this subsection during such period of temporary or permanent partial general disability not exceeding a maximum of 415 weeks. . . . Permanent partial general disability exists when the employee is disabled in a manner which is partial in character and permanent in quality and which is not covered by the schedule in K.S.A. 44-510d and amendments thereto. The extent of permanent partial general disability shall be the extent, expressed as a percentage, to which the employee, in the opinion of the physician, has lost the ability to perform the work tasks that the employee performed in any substantial gainful employment during the fifteen-year period preceding the accident, averaged together with the difference between the average weekly wage the worker was earning at the time of the injury and the average weekly wage the worker is earning after the injury. In any event, the extent of permanent partial general disability shall not be less than the percentage of functional impairment. Functional impairment means the extent, expressed as a percentage, of the loss of a portion of the total physiological capabilities of the human body as established by competent medical evidence and based on the fourth edition of the American Medical Association Guides to the Evaluation of Permanent Impairment, if the impairment is contained therein. An employee shall not be entitled to receive permanent partial general disability compensation in excess of the percentage of functional impairment as long as the employee is engaging in any work for wages equal to 90% or more of the average gross weekly wage that the employee was earning at the time of the injury.

K.S.A. 44-510d(a) states in part:

> Where disability, partial in character but permanent in quality, results from the injury, the injured employee shall be entitled to the compensation provided in K.S.A. 44-510h and 44-510i and amendments thereto, but shall not be entitled to any other or further compensation for or during the first week following the injury unless such disability exists for three consecutive weeks, in which event compensation shall be paid for the first week. Thereafter compensation shall be paid for temporary total loss of use and as provided in the following schedule, 66

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[5] *Graff v. Trans World Airlines*, 267 Kan. 854, 864, 983 P.2d 258 (1999).

[6] *Tovar v. IBP, Inc.*, 15 Kan. App. 2d 782, 784, 817 P.2d 212, *rev. denied* 249 Kan. 778 (1991).

> 2/3% of the average gross weekly wages to be computed as provided in K.S.A. 44-511 and amendments thereto, except that in no case shall the weekly compensation be more than the maximum as provided for in K.S.A. 44-510c and amendments thereto. If there is an award of permanent disability as a result of the injury there shall be a presumption that disability existed immediately after the injury and compensation is to be paid for not to exceed the number of weeks allowed in the following schedule:
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> . . . .
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> (13) For the loss of an arm, excluding the shoulder joint, shoulder girdle, shoulder musculature or any other shoulder structures, 210 weeks, and for the loss of an arm, including the shoulder joint, shoulder girdle, shoulder musculature or any other shoulder structures, 225 weeks.
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> . . . .
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> (23) Loss of a scheduled member shall be based upon permanent impairment of function to the scheduled member as determined using the fourth edition of the American Medical Association Guides to the Evaluation of Permanent Impairment, if the impairment is contained therein.

ANALYSIS

Both Dr. McAtee and Dr. Hufford considered the appropriate rating for claimant's impairment to be to the upper extremity, not to the spine, neck or body as a whole. Dr. Hufford stated:

> Q. [by claimant's attorney] Were any of the–or do you know if any of the muscles that were damaged around the scapula were related to or connected to the cervical or thoracic spine?
>
> A. [by Dr. Hufford] Well, they wouldn't be considered directly a part of the cervical or thoracic spine. The muscles that are directly involved in the axial spine are referred to as the paraspinals. When you get away from them you do start to develop muscular attachments. But I do not consider them directly a part of the axial spine itself.
>
> Q. Are they connected in any way to the axial spine or when you say the axial spine what are you referring to?
>
> A. I'm referring to the vertebrae of the cervical and thoracic spine, the actual vertebrae themselves.
>
> Q. Are the muscles coming off of the cervical and thoracic spine connected to the shoulder blade?
>
> A. No.[7]

Dr. Hufford considered claimant's neck pain to be referred pain from the left shoulder, not a separate cervical spine condition. The AMA *Guides* does not provide a rating for referred pain, but it does provide for rating pain. When asked to, Dr. Hufford provided a hypothetical whole body impairment rating. Nevertheless, he did not believe providing a

[7] Hufford Depo. at 7-8.

separate rating for claimant's neck pain was warranted in claimant's case under the *Guides*. His ultimate opinion was that claimant had a 12 percent left upper extremity impairment. The ALJ found this opinion to be the most credible, and the Board agrees. The Board adopts the ALJ's findings and conclusions as to the nature and extent of claimant's disability as its own.

CONCLUSION

Claimant is entitled to an award of permanent partial disability compensation based upon a 12 percent permanent impairment of function to his left upper extremity at the level of the shoulder.

AWARD

WHEREFORE, it is the finding, decision and order of the Board that the Award of Administrative Law Judge John D. Clark dated May 7, 2010, is modified to find claimant's gross average weekly wage is $849.85 but is otherwise affirmed.

IT IS SO ORDERED.

Dated this _____ day of August, 2010.

_____
BOARD MEMBER

_____
BOARD MEMBER

_____
BOARD MEMBER

c: Roger A. Riedmiller, Attorney for Claimant
Ali N. Marchant, Attorney for Respondent and its Insurance Carrier
John D. Clark, Administrative Law Judge